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Technical change: formatting, numbering, word order, or language changes; no change in intent or practice;
Codifying existing practice: new or changed language, no change in practice;
Policy change: new language, new practice.

Cite Change	Effect / Benefits
31A-1-301 - Definitions	
53 As used in this title, unless otherwise specified: . . . 887 (133) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 888 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and 889 related federal regulations and guidance. . . . 1076 [~~(161)~~] (162) (a) "Surplus" means the excess of assets over the sum of paid-in capital 1077 and liabilities. 1078 (b) (i) "Permanent surplus" means the surplus of [~~a mutual~~] an insurer or organization 1079 that is designated by the insurer or organization as permanent. 1080 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and [~~31A-14-209~~] 1081 31A-14-205 require that [~~mutuals~~] insurers or organizations doing business in this state 1082 maintain specified minimum levels of permanent surplus.	**Codifies existing practice.** Adds a definition to the Insurance Code to reference the Patient Protection and Affordable Care Act (ACA). **Technical change:** Replaces reference to inapplicable code cite and clarifies applicability of definition of "permanent surplus" to insurers and HMOs (organizations).
31A-2-404. Duties of the commissioner and Title and Escrow Commission.	
1181 (1) Notwithstanding the other provisions of this chapter, to the extent provided in this 1182 part, the commissioner shall administer and enforce the provisions in this title related to: 1183 (a) title insurance; and 1184 (b) escrow conducted by a title licensee or title insurer. 1185 (2) The commission shall: 1186 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and 1187 subject to Subsection [(3)] (4), make rules for the administration of the provisions in this title 1188 related to title insurance including rules related to: 1189 (i) rating standards and rating methods for a title licensee, as provided in Section	**Policy and technical change –** With the support of the Title and Escrow Commission, this change corrects a conflict with 31A-23a-204, which is addressed later in this bill, by modifying existing law to make rulemaking authority for the Title and Escrow Commission, related to establishing an examination of a licensee, **permissive** as opposed to **mandatory**. *Requested by the Insurance Department with concurrence of the Title and Escrow Commission*

1190 31A-19a-209; 1191 (ii) the licensing for a title licensee, including the licensing requirements of Section 1192 31A-23a-204; 1193 (iii) continuing education requirements of Section 31A-23a-202; and 1194 [~~(iv) examination procedures, after consultation with the commissioner and the~~ 1195 ~~commissioner's test administrator when required by Section 31A-23a-204; and~~] 1196 [~~(v)~~] (iv) standards of conduct for a title licensee; . . . 1222 (3) The commission may make rules establishing an examination for a license that will 1223 satisfy Section 31A-23a-204: 1224 (a) after consultation with the commissioner and the commissioner's test administrator; 1225 (b) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and 1226 (c) subject to Subsection (4). . . .	
31A-3-304. *(Effective 07/01/13)*. Annual fees – Other taxes or fees prohibited – Captive Insurance Restricted Account.	
1250 (1) (a) A captive insurance company shall pay an annual fee imposed under this section 1251 to obtain or renew a certificate of authority. . . . 1286 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing, 1287 except that at the end of each fiscal year, money received by the commissioner in excess of 1288 [~~$950,000~~] $1,250,000 shall be treated as free revenue in the General Fund.	**Policy change.** Increases non-lapsing authority from $950,000 to 1,250,000 in FY 2015 to grow Captive Division resources commensurate with robust growth of captive insurers domiciled in Utah. The increase is critical to maintain Utah's competitive advantage of being a thorough, responsive and consistent regulator of captive insurers.
31A-8-301. Requirements for doing business in state.	
1291 (1) Only a corporation incorporated and licensed under Part 2, Domestic 1292 Organizations, may do business in this state as an organization. 1293 (2) To do business in this state as an organization, a foreign [~~corporations~~] corporation 1294 doing a similar business in other states shall incorporate a subsidiary and license [~~if~~] it under 1295 Part 2, Domestic Organizations, for its Utah business. Except as to Chapter 16, Insurance 1296 Holding Companies, the laws applicable to a domestic [~~organizations~~] organization apply only	**Technical change.** Corrects typographical error, by changing the word "if" to "it" and plural "organizations" to singular "organization" in reference to a subsidiary.

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1297 to the domestic organization and not to its foreign parent corporation.	
31A-17-603. Company action level event.	
1300 (1) "Company action level event" means any of the following events: 1301 (a) the filing of an RBC report by an insurer or health organization that indicates that: 1302 (i) the insurer's or health organization's total adjusted capital is greater than or equal to 1303 its regulatory action level RBC but less than its company action level RBC; [~~or~~] 1304 (ii) if a life or health insurer, the insurer has: 1305 (A) total adjusted capital that is greater than or equal to its company action level RBC 1306 but less than the product of its authorized control level RBC and [~~2.5~~] 3.0; and 1307 [~~(B) a negative trend, determined in accordance with the "trend test calculation"~~ 1308 ~~included in the RBC instructions;~~] 1309 (B) triggers the trend test determined in accordance with the trend test calculation 1310 included in the life or fraternal RBC instructions; or 1311 (iii) if a property and casualty insurer, the insurer has: 1312 (A) total adjusted capital that is greater than or equal to its company action level RBC, 1313 but less than the product of its authorized control level RBC and 3.0; and 1314 (B) triggers the trend test determined in accordance with the trend test calculation 1315 included in the property and casualty RBC instructions; 1316 (b) the notification by the commissioner to the insurer or health organization of an 1317 adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health 1318 organization does not challenge the adjusted RBC report under Section 31A-17-607; or . . .	**Policy change.** Updates and strengthens risk based capital solvency trend calculation standard consistent with required accreditation standards for life insurers, fraternal organizations and property and casualty insurers. The Insurance Department indicates that there are currently NO Utah insurance companies that will be impacted by this change. *Requested by the Insurance Department*
31A-22-429. Producer's duties related to replacement of life insurance or annuity	
1387 (1) In connection with or as part of each application for life insurance or annuities, the 1388 applicant shall complete and the producer shall submit to the insurer the statements required by 1389 rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act as to: 1390 (a) whether the applicant has existing policies or contracts; and 1391 (b) whether the proposed life insurance or annuity will replace, discontinue, or change 1392 an existing policy or contract. 1393 (2) (a) If an applicant for life insurance or an annuity answers "yes" to the question	**Codifying existing practice:** This is merely the codification of existing rule R590-93. There is no substantive change in the meaning or requirements imposed on a producer in the context of the replacement of a life insurance or annuity contract.

regarding replacement, discontinuance, or change of an existing policy or contract referred to in Subsection (1), the producer shall present to the applicant, not later than at the time of taking the application, the notice regarding replacements in the form adopted by the commissioner by Rulemaking Act, or other substantially similar document filed with the commissioner. However, a filing is not required when an amendment to the notice is limited to the omission of a reference not applicable to the product being sold or replaced.

(b) The notice described in Subsection (2)(a) shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud, in which case the producer need not have read the notice aloud, and left with the applicant. With respect to an electronically completed application and notice, the producer is not required to leave a copy of the electronically completed notice with the applicant.

(3) (a) The notice described in Subsection (2)(a) shall:

(i) list each existing policy or contract contemplated to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and

(ii) include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract.

(b) If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(4) In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract holder in printed form no later than at the time of policy or contract delivery.

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(5) Except as provided in rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented: (a) a copy of each document required by this section; (b) a statement identifying any preprinted or electronically presented company approved sales materials used; and (c) copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.	
31A-22-519. Death pending conversion.	
If a person insured under a group life insurance policy, or the insured dependent of that person, dies during the period of eligibility for conversion under Section 31A-22-517 or 31A-22-518 and before the individual policy becomes effective, the amount of life insurance to which [~~he~~] the insured would have been entitled to have issued under the individual policy is payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium has been made.	**Technical change.** The language clarifies that the amount payable if death occurs during the conversion period for group life insurance will be the amount the certificate holder is eligible for under an individual policy, which may result in a decrease in the amount of the death benefit payable during the conversion period. The proposed change returns language omitted in the 1986 recodification, is consistent with national standards, and the prevailing practice in the group life insurance industry. *Requested by the Department*
31A-22-617. Preferred provider contract provisions.	
Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows: . . . (2) (a) Subject to Subsections (2)(b) through (2)[~~(f)~~](e), an insurer using preferred health care provider contracts [~~shall pay for the services of health care providers not under the contract, unless the illnesses or injuries treated by the health care provider are not within the scope of the insurance contract. As used in this section, "class of health care providers"~~	**Technical change.** On July 1, 2012, a 2011 legislative change (HB128S2 Health Reform Amendments) became effective, This change removes a previous requirement for insurer's (excluding HMO's) to pay for non-contracted providers at a level no less than 75% of the average payment to insurers. Due to this change, the provisions in 31A-22-618.5, which allow insurers to offer plans with limited mandates, became very confusing. This change is an attempt to more clearly describe the available plan offerings. *Requested by the Department*

~~means~~
~~all health care providers licensed or licensed and certified by the state within the same professional, trade, occupational, or facility licensure or licensure and certification category established pursuant to Titles 26, Utah Health Code and 58, Occupations and Professions~~] is subject to the reimbursement requirements in Section 31A-8-501.

~~[(b) (i) Until July 1, 2012, when the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers.]~~

~~[(ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that complies with the provisions of Subsection 31A-22-618.5(3).]~~

~~[(iii) The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for comparable services of preferred health care providers who are members of the same class of health care providers.]~~

~~[(c)]~~ (b) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

~~[(d) Notwithstanding Subsection (2)(b), an]~~ (c) An insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

~~[(e)]~~ (d) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

~~[(f)]~~ (e) For purposes of this section, unfair discrimination between classes of health care providers [~~shall~~] include:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are: (A) commonly [~~utilized~~] used by members of the class of health care providers for the treatment of illnesses, injuries, or conditions; (B) otherwise covered by the insurer; and (C) within the scope of practice of the class of health care providers. . . . (9) Insurers are subject to [~~the provisions of~~] Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.	
31A-22-618.5. Health benefit plan offerings.	
(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans: [~~(a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that groups providers into the following reimbursement levels:~~] [~~(i) tier one contracted providers;~~] [~~(ii) tier two contracted providers who the insurer shall reimburse at least 75% of tier one providers; and~~] [~~(iii) one or more tiers of non-contracted providers;~~] [~~(b)~~] (a) notwithstanding Subsection 31A-22-617(9), may offer a health benefit plan that is not subject to Section 31A-22-618; [~~(c) beginning July 1, 2012, may offer health benefit plans that:~~] [~~(i) are not subject to Subsection 31A-22-617(2); and~~] [~~(ii) are subject to the reimbursement requirements in Section 31A-8-501;~~] [~~(d)~~] (b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627 [~~by providing coverage at a reimbursement level of at least 75% of the health benefit plan's highest contracted provider category~~]; [~~(e)~~] (c) are not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009. (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b). (5) (a) Any difference in price between a health benefit plan offered under Subsections	**Technical change.** The language is no longer applicable due to a 2011 legislative change (HB128S2 Health Reform Amendments) which removed a previous requirement for insurer's (excluding HMO's) to pay for non-contracted providers at a level no less than 75% of the average payment to insurers. *Requested by the Department*

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1640 (2)(a) and (b) shall be based on actuarially sound data. 1641 (b) Any difference in price between a health benefit plan offered under [~~Subsections~~] 1642 Subsection (3)(a) [~~and (b)~~] shall be based on actuarially sound data.	
31A-22-724. Offer of alternative coverage – Utah NetCare Plan.	
1647 (1) For purposes of this section, "alternative coverage" means: 1648 (a) a high deductible or low deductible Utah NetCare Plan described in Subsection (2) 1649 for a conversion health benefit plan policy offered under Section 31A-22-723; and 1650 (b) a high deductible and low deductible Utah NetCare Plans described in Subsection 1651 (2) as an alternative to COBRA and mini-COBRA health benefit plan coverage offered under 1652 Section 31A-22-722. . . . 1736 (7) (a) [~~(i)~~] If alternative coverage is selected as an alternative to COBRA or 1737 mini-COBRA health benefit plan coverage under Section 31A-22-722[~~,~~]: 1738 (i) Section 31A-22-722 applies to the alternative coverage[~~.~~]; 1739 (ii) [~~If an employee of a small employer selects alternative coverage as an alternative to~~ 1740 ~~COBRA or mini-COBRA health benefit plan coverage,~~] the insurer may not use a risk factor 1741 greater than the employer's most current risk factor for purposes of Subsection 1742 31A-22-722(5)[~~.~~]; and 1743 (iii) the insurer shall credit to the alternative coverage the current year's deductible and 1744 out of pocket amounts satisfied under the employer's plan. 1745 (b) If alternative coverage is selected as a conversion policy under Section 1746 31A-22-723[~~,~~]: 1747 (i) Section 31A-22-723 applies[~~.~~]; and 1748 (ii) the insurer shall credit to the alternative coverage the current year's deductible and 1749 out of pocket amounts satisfied under the employer's plan. . . .	**Policy change.** The change requires an insurer, when issuing a Utah NetCare plan, to credit the deductible and out of pocket limits based on amounts previously credited to the employer plan. Currently there is no provision in code addressing this issue. *Requested by the Department*
31A-23a-204. Special requirements for title insurance producers and agencies.	
1755 A title insurance producer, including an agency, shall be licensed in accordance with 1756 this chapter, with the additional requirements listed in this section. . . . 1800 (6) The Title and Escrow Commission [~~shall~~] may adopt rules, subject to Section	**Policy and technical change.** This is the second part of what was mentioned earlier regarding 31A-2-404 and correction of a conflict by modifying existing law from requiring the Title and Escrow Commission to

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1801 31A-2-404, after consulting with the ~~[department]~~ commissioner and the ~~[department's]~~ 1802 commissioner's test administrator, establishing an examination for a license that will satisfy 1803 this section. . . .	promulgate rules for the specific purpose of establishing an examination of a licensee, from mandatory to permissive. The Title and Escrow Commission supports this change.
31A-23a-402.5. Inducements.	
1819 (1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee 1820 under this title, or an officer or employee of a licensee, may not induce a person to enter into, 1821 continue, or terminate an insurance contract by offering a benefit that is not: 1822 (i) specified in the insurance contract; or 1823 (ii) directly related to the insurance contract. 1824 (b) An insurer may not make or knowingly allow an agreement of insurance that is not 1825 clearly expressed in the insurance contract to be issued or renewed. . . . 1850 (4) Items not prohibited by Subsection (1) include a producer, consultant, or other 1851 licensee, or an officer or employee of a licensee, either directly or through a third party: . . . 1922 (v) facilitating risk management services directly related to ~~[the]~~ property and casualty 1923 insurance ~~[product]~~ products sold or offered for sale by the licensee, including: 1924 (i) risk management;	There are two types of changes to section 402.5 of Chapter 23a. **A. Codifying existing practice:** clarifies by adding the words "producer, consultant, or other" in several places in the section that this section, related to inducements, specifically applies to producers and consultants as well as other licensees. **B. Policy change.** These next two proposed changes are related to concerns with the anti-inducement law related to property and casualty lines of insurance. 1) **31A-23a-402.5(4)(v)** – clarify that risk management relates to property and casualty insurance lines only and clarify what may be provided in risk assessment consulting.

1925 (ii) claims and loss control services; ~~[and]~~ 1926 (iii) risk assessment consulting~~[;]~~, <u>including analysis of:</u> 1927 <u>(A) employer's job descriptions;</u> 1928 <u>(B) employer's safety procedures or manuals; and</u> 1929 <u>(iv) providing information and training on best practices;</u> … 1933 (5) An inducement prohibited under Subsection (1) includes a <u>producer, consultant, or</u> 1934 <u>other</u> licensee, or an officer or employee of a licensee: . . . 1941 (b) engaging in one or more of the following unless a fee is paid in accordance with 1942 Subsection ~~[(7)]~~ <u>(8)</u>: 1943 (i) performing background checks of prospective employees; 1944 (ii) providing legal services by a person licensed to practice law; 1945 (iii) performing drug testing that is directly related to an insurance product purchased 1946 from the licensee; 1947 (iv) preparing employer or employee handbooks, except that a licensee may: 1948 (A) provide information for a medical benefit section of an employee handbook; 1949 (B) provide information for the section of an employee handbook directly related to an 1950 employment practices liability insurance product purchased from the licensee; or 1951 (C) prepare or print an employee benefit enrollment guide; 1952 (v) providing job descriptions, postings, and applications for a person ~~[that purchases~~ 1953 ~~an employment practices liability insurance product from the licensee]~~; 1954 (vi) providing payroll services; 1955 (vii) providing performance reviews or performance review training; 1956 (viii) providing union advice; 1957 (ix) providing accounting services; 1958 (x) providing data analysis information technology programs, except as provided in 1959 Subsection (4)(h)(ii); 1960 (xi) providing administration of health reimbursement accounts or health savings 1961 accounts; or 1962 (xii) if the licensee is an insurer, or a third party administrator who contracts with an 1963 insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of	2) **31A-23a-402.5(5)(a)(v)** – clarify that a licensee is not allowed to provide job descriptions to either current *or* perspective clients.

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the following prohibited benefits: (A) performing background checks of prospective employees; (B) providing legal services by a person licensed to practice law; (C) performing drug testing that is directly related to an insurance product purchased from the insurer; (D) preparing employer or employee handbooks; (E) providing job descriptions postings, and applications; (F) providing payroll services; (G) providing performance reviews or performance review training; (H) providing union advice; (I) providing accounting services; (J) providing discrimination testing; or (K) providing data analysis information technology programs. (6) A producer, consultant, or other licensee or an officer or employee of a licensee shall itemize and bill separately from any other insurance product or service offered or provided under Subsection (5)(b) ~~[(6)]~~ (7) A de minimis gift or meal not to exceed $25 for each individual receiving the gift or meal is presumed to be a social courtesy not conditioned on the quote or purchase of a particular insurance product for purposes of Subsection (4)(a). ~~[(7)]~~ (8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is paid a fee to provide an item listed in Subsection (5)(b), the licensee shall comply with Subsection 31A-23a-501(2) in charging the fee, except that the fee paid for the item shall equal or exceed the fair market value of the item. . . .	3) **31A-23a-402.5(6)** – This change requires that services provided for which the fair market value must be paid are itemized and billed individually instead of in a lump sum. 4) **31A-23a-402.5(7)** – Here, the change adds getting an insurance *quote* to the prohibition of conditioning the giving of a de minimis gift or meal to a person that purchases an insurance product.
31A-29-113. Benefits – Additional types of pool insurance-preexisting conditions-waiver-Maximum benefits	
(10) Covered benefits available from the pool may not exceed a ~~[$1,500,000]~~ $1,800,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.	**Policy change.** Raises the lifetime maximum benefit for individuals in HIPUtah from $1.5 million to $1.8 million. This change mirrors action taken by the HIPUtah Board.

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31A-31-108. Assessment of insurers.	
2078 (4) (a) There is created in the General Fund a restricted account known as the 2079 estricted Account." 2080 (b) The Insurance Fraud Investigation Restricted Account shall consist of the money 2081 received by the commissioner under this section and ~~[Section 31A-31-109.]~~ Subsections 2082 31A-31-109(1)(a)(ii), (1)(b), (2)(b)(i), (2)(c), and (3)(a). Money ordered paid under Subsection 2083 31A-31-109(1)(a)(i) and (2)(a) shall be deposited in the Insurance Fraud Victim Restitution 2084 Fund pursuant to Section 31A-31-108.5. 2085 (c) The commissioner shall administer the Insurance Fraud Investigation Restricted 2086 Account. Subject to appropriations by the Legislature, the commissioner shall use the money 2087 deposited into the Insurance Fraud Investigation Restricted Account to pay for a cost or 2088 expense incurred by the commissioner in the administration, investigation, and enforcement of 2089 insurance fraud provisions.	**Policy change.** These last two changes relate to the Insurance Fraud Division's ability to forward restitution funds ordered by the court to victims. The change creates the Insurance Fraud Victim Restitution Fund. With the change, the full amount of restitution received by the Fraud Division as ordered by a court in a criminal insurance fraud case will be deposited in the Fund. The full amount of those restitution funds will then be paid to the victims as ordered by the judge. Approval of this change does NOT affect any aspects of the Fraud Division's operational expenses or General Fund revenue in any way, the Fund will function solely as the account through which restitution monies 'pass through' from the defendants to the victims. *[The amount of restitution collected is dictated by the types of cases prosecuted each year and the relevant court orders. This amount can vary dramatically, this fiscal year, the Department is appropriated $322,300 for restitution and is on track to well exceed that amount. Last FY the Department paid out $394,200 in restitution. The Department is simultaneously seeking budget approval for an increase in appropriation for the Victim Restitution Fund to $750,000, however, authority to pass through actual restitution monies to victims is preferable to telling a victim the Department has the money but does not have authority to disburse it or seek a "blank check" appropriation authority. The Commissioner would like to avoid the potential of being on Gephardt explaining that the State has a victim's money but does not have budgetary authority to pay the victim – this change alleviates that potential.]* *Requested by the Department*

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31A-31-108.5. Insurance Fraud Victim Restitution Fund.	
(1) There is created a restricted special revenue fund known as the "Insurance Fraud Victim Restitution Fund." (2) The Insurance Fraud Victim Restitution Fund shall consist of money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a). (3) Interest on fund money shall be deposited into the General Fund. (4) The commissioner shall administer the Insurance Fraud Victim Restitution Fund for the sole benefit of insurance fraud victims.	**Policy change.** Same as above. *Requested by the Department*
Effective Dates	
This bill takes effect on May 14, 2013, except that the amendment to Section 31A-3-304 (Effective 07/01/13) takes effect on July 1, 2015.	This is the increase in the captive account cap